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	17E294	A. BUILDING _____ B. WING _____	R-C 09/29/2015

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{F 000}	INITIAL COMMENTS The following citations represent the findings of a Non-compliance Revisit and Complaint investigation #90713,90711,90553.	{F 000}		
F 223 SS=K	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: The facility identified a census of 26 residents with 7 residents sampled. Based on observation, interview, and record review the facility failed to provide adequate supervision to protect the [gender] residents from resident-to-resident sexual abuse from resident #11, which placed 19 [gender] residents in immediate jeopardy. Findings included: - The admission Minimum Data Set Assessment (MDS) for resident #11, dated 8/19/15 recorded the resident with a BIMS of 7, which indicated severe cognitive impairment. The resident required supervision and set up with all activities of daily living, exhibited steady balance, and used a walker for ambulation. The Care Area Assessment (CAA) dated 8/29/15 for cognition recorded the resident ' s BIMS score	F 223		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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of 7 and diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure. The resident wandered daily and almost continually while awake. During the review period, staff documented daily wandering on the behavior flow sheets. The nurse ' s notes recorded the resident exhibited sexually inappropriate behaviors.

The CAA for behaviors dated 8/29/15 documented the resident wandered throughout facility all day while awake, exit seeking. Staff documented sexually inappropriate behaviors in the nurses ' notes with a recent history of hypersexual phases. During this review period, nursing staff met with the resident ' s family and discussed transferring him/her to senior behavioral health for medication review due to increased behaviors.

Review of the interim plan of care dated 8/10/15 recorded the resident was cognitively impaired, hearing impaired, wore hearing aids, and did not understand the staff. The resident transferred with an assistive device, and independent with ambulation and locomotion.
The interim plan of care lacked any interventions to direct staff for resident behaviors.

The physician admission history and physical dated 8/10/15 documented the physician changed the resident ' s Depo-Provera from 75 milligrams every 2 weeks to 150 milligrams intramuscularly every month, due for another injection tomorrow. The resident tends to take off all his/her clothing at times during the day. The resident was oriented to person only. The resident continued with rapidly progressive cognitive loss from dementia over the past 18

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months and appears to have progressed possibly from his/her recent hypersexual phase.

Review of the physician admission orders dated 8/10/15 lacked any order for Depo-Provera. The clinical record lacked documentation of follow up with the physician regarding an order for Depo-Provera.

Nursing note on 8/11/15 at 9:39 A.M. documented the resident was alert, confused, and wandered.

Nursing note dated 8/11/15 timed 4:01 P.M. recorded staff administered the medication Lorazepam 0.5 milligrams for the resident ' s anxiety.

Nursing note dated 8/11/15 at 9:39 P.M. documented the resident alert, confused, and wandered most of the evening, often without his/her walker.

Nursing note date 8/13/15 at 3:29 A.M. recorded the resident wandered from door to door, chair to chair, and hall to hall until approximately 9:30 P.M. The resident went to sleep for approximately 15 minutes. Staff had redirected the resident back to his/her room and helped to bed several times.

Nursing note dated 8/14/15 at 8:07 P.M. recorded staff notified the physician of wandering behaviors and increased anxiety. The physician ordered the medication Seroquel (an antipsychotic medication) 25 milligrams orally to be administered once.

Nursing note dated 8/16/15 at 10:33 P.M. documented a staff member found the resident in

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a [gender] resident ' s room touching the [gender] resident ' s breasts. Staff redirected the resident after some resistance, and then notified the director of nursing and physician.
The clinical record lacked any interventions to protect the [gender] residents in the facility.

The physician response to a facsimile dated 8/16/15 at 10:42 pm, ordered to restart Depo-Provera 150 milligrams intramuscularly every 2 weeks for sexual impulse disorder.

Review of the facility provided investigation dated 8/20/15, (for the 8/16/15 10:30 P.M. incident) documented direct care staff P observed the resident in resident #13 ' s room touching the resident ' s breasts and redirected resident #11 from the room. The facility investigation documented the plan to continue hourly visual checks on resident #11, monitor effectiveness of medication changes, allow the resident to wander, and redirect as necessary.

Nursing note dated 8/17/15 at 5:21 P.M. documented staff administered the physician ordered Depo-Provera injection.

Nursing notes dated 8/18/15 at 12:41 A.M. staff found the resident up walking around in his/her room naked at 12:15 A.M.

Nursing notes dated 8/20/15 at 8:29 A.M., recorded the resident experienced a very rough evening and night, confused and delusional, with nonstop pacing and exit seeking. The resident pushed his/her walker very fast with an urgent concern look on his/her face. The resident was unable to sit still, diaphoretic (excess sweating) and becoming tired and unsteady on feet. Unable

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to verbalize what he/she was trying to do. The resident ' s behavior had not slowed down or changed and night shift reported the resident did not sleep well and was up and down all night. Nursing staff notified the resident ' s physician about the resident ' s behaviors.

Nursing notes dated 8/20/15 timed 2:00 P.M. documented a physician order to increase the medication Seroquel to 50 milligrams on the evening dose. Nursing staff would continue to monitor until the Psychiatrist saw the resident on Monday, 8/24/15.

Nursing notes dated 8/20/15 at 3:03 P.M. documented throughout the afternoon, the resident continued to go to all doors. The staff continued to redirect the resident with minimal results.

Social notes dated 8/20/15 at 4:31 P.M. documented calls to behavioral health units. Staff anticipated a transfer to a behavioral unit on 8/21/15.

Nursing note dated 8/21/15 at 1:19 A.M. documented staff found the resident exiting out of a [gender] peers (resident #17) room and redirected the resident back to his/her room. When asked, resident #17, reported resident #11 walked in and touched his/her shoulder, and he/she yelled at him/her to leave, and he/she left the room. Staff reminded the resident that he/she cannot go into another resident ' s room. Nursing staff sent a facsimile to the physician and notified the director of nursing. The clinical record lacked any additional interventions to protect the [gender] residents in the facility.

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Review of the incomplete facility investigation dated 8/21/15 documented a licensed nursing staff witnessed the resident leaving resident #17 ' s room and shutting the door. Resident #17 reported resident #11 touched him/her on the shoulder and he/she was startled and yelled out in fright. Resident #17 stated, " [He/she] scared me. " Staff redirected the resident back to his/her room across the hallway from resident #17.

Nursing note dated 8/21/15 at 1:21 A.M., documented staff would place the resident on 15-minute checks to make sure he/she did not enter another peers ' room.
The clinical record lacked evidence of any 15-minute checks.

Nursing note dated 8/21/15 timed 1:39 P.M. documented the facility transferred the resident to an acute hospital behavior unit.

Observation on 9/17/15 at 1:40 P.M. revealed the cognitively impaired resident #13 seated in a reclined Broda chair. The resident was nonverbal, unable to converse, and totally dependent on staff for all activities of daily living.

During an interview on 9/17/15 at 3:50 P.M. administrative nursing staff D reported the night of the incident between resident #11 and resident #13, nursing staff increased his/her hourly checks to 15-minute checks. The next morning, since his/her behaviors had dissipated, staff stopped the frequent checks, back to hourly as the resident continued wandering. The licensed charge nurse monitored the resident hourly. Administrative nursing staff D revealed staff did not place the resident on one to one observations after the resident-to-resident sexual advances.

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On 9/17/15 at 4:47 P.M. administrative nursing staff D reported, nursing staff did not increase monitoring the resident to 15-minute checks and there was no documentation of any 15-minute checks during the resident ' s admission.

On 9/18/15 at 12:35 P.M. licensed nursing staff G revealed the resident walked independently with a walker, had a lot of anxiety, required cueing and staff monitored the resident ' s location hourly due to the fall and elopement risk.

On 9/18/15 at 1:20 P.M. direct care staff Q reported the resident was confused, ambulated independently with a walker and went in and out of resident rooms. Direct care staff Q revealed when the facility readmitted the resident, he/she was placed on a different hall from the first admission, which seemed to confuse the resident.

On 9/18/15 at 1:40 P.M. direct care staff N reported the resident was an elopement risk, wandered all the time, and would go in and out of other resident rooms. Direct care staff N revealed only one resident on C-hall (resident #13 ' s hall) was cognitively able to complain or report any abuse.

During an interview on 9/18/15 at 3:05 pm, resident #17 reported he/she only had one problem at the facility. It was the night someone came into his/her room. " It startled me and scared me. "

On 9/21/15 at 1:15 P.M. direct care staff O reported the resident wandered in the facility and forgot to use the assistive walker when he/she

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became anxious, about half the time. The resident wandered in and out of others rooms.

The facility provided policy Abuse, Neglect, and Exploitation Policy and Procedure dated 8/2012 directed that all persons within the facility have the right to be free from abuse. Sexual abuse included sexual harassment, sexual coercion, or sexual assault. Protection was provided to the resident or patient during the investigation of the alleged abuse.

The facility provided policy Resident-to-Resident Altercations dated December 2007 documented all altercations, including those that may represent resident-to-resident abuse were investigated and reported to the nursing supervisor, the director of nursing services, and the administrator. The facility staff monitored residents for aggressive/inappropriate behavior towards other residents. If two residents were involved in an altercation, staff would separate the residents and institute measures to calm the situation.

The facility failed to protect the residents in the facility from resident #11 ' s sexual advances, identified with hypersexual behavior, when the staff failed to provide adequate supervision to protect the [gender] residents in the facility from unwelcomed sexual advances on 8/16/15, with resident #13, a cognitively impaired dependent resident, and on 8/21/15, resident #17, identified as alert and oriented, which placed the [gender] residents in the facility in immediate jeopardy.

The facility corrected the deficiency on 8/21/15 when the resident transferred out of the facility to a behavior unit.

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The facility abated the immediate jeopardy on 9/24/15 when they did all staff training at 2:00 P.M. when:
The facility would ensure the safety of all residents from the aggressor:
1. Consult the PCP (primary care physician), DON (director of nursing), and family regarding incident and behaviors.
2. Assess the aggressor ' s behavior for up to 72 hours along with any contributing factors for behavior.
3. Consult mental health regarding aggressor.
4. Monitor the aggressor by making them a " one on one " until transfer or behaviors subside.
5. Update the care plan per physician ' s orders and re-evaluate interventions and medications if indicated.
The facility would ensure the safety of the resident who was the recipient of inappropriate behaviors:
6. Full body assessment with vital signs and verbal interview of occurrence.
7. Offer emotional support to resident per their preference.
8. Contact family, PCP, DON, and update care plan per physician ' s orders.
9. Re-evaluate and monitor residents for emotional distress.
10. The policy will be in effect immediately and staff will be educated by read and sign through the weekend.
11. Staff would be educated daily in person on new policy up to 9/24/15, when " All Staff " meeting occurs. All staff will be trained in person that day.
12. Yearly education would be provided.
13. The policy would be provided in New Employee Orientation Packet and reviewed at

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F 223	Continued From page 9 annual ANE (abuse, neglect, and exploitation) training. This deficient practice remains at the scope and severity of a E.	F 223		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: The facility identified a census of 26 residents. Based on observation, interview, and record review the facility failed to provide necessary care and services during transfers to prevent an avoidable fractured leg for 1 (#10) of 6 cognitively impaired dependent residents reviewed for falls. Findings included: - The facility electronic health records documented resident #10 with diagnosis that included dementia with behavioral disturbances and history of an open fractured femur (thighbone) on 2/2/14. The significant change Minimum Data Set Assessment (MDS) dated 4/22/15 recorded the resident with a BIMS (Brief Interview for Mental Status) of 00, which indicated severe cognitive	F 224		

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impairment. The resident exhibited verbal and physical behaviors that significantly interfered with participation in activities or socialization. The resident required extensive assistance of two or more staff for bed mobility, transfers, dressing, and toileting, exhibited unsteady balance and only able to stabilize with assistance from staff, and used a wheelchair for mobility.

The Care Area Assessment (CAAs) dated 5/9/15 documented the resident experienced a fall on 4/8/15 that resulted in a cervical spine (neck) fracture.

The completed mobility assessments dated 4/15/15 and 7/18/15, recorded the resident required staff assistance with a sit to stand lift for transfers.

The quarterly MDS dated 7/23/15 documented the resident with a BIMS score of 2, which indicaed severe cognitive impairment. He/she required extensive assistance of two staff for transfers, and experienced a non-injury fall since the previous assessment.

The fall assessment dated 7/9/15 documented the resident with a score of (55), which recorded the resident was a high risk for falls.

Review of the plan of care dated 1/5/15 recorded the resident with limited physical mobility related to the disease process and dementia with behavioral disturbance. The care plan directed the resident was totally dependent on two staff members for transfers. Staff used the sit-to-stand (Sera Life) for transfers, during toileting, and periods of agitation. The resident required two staff and a gait belt (belt used to help transfer a

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person from one place to another) to walk a few steps or pivot transfer dependent upon the resident ' s physical ability. Staff used the sit-to-stand lift when the resident was unable to pivot with staff for safety.
Intervention added on 8/28/15 directed staff to ensure the ankle brace was in place except when the resident was sleeping.

Nursing note dated 8/16/15 timed 9:28 P.M. documented one staff transferred the resident from the recliner to a wheelchair when the resident said "Ouch, my ankle". The resident favored his/her right ankle, and would not place the foot on the floor or use it. Nursing staff assessed the resident ' s ankle symmetrical with the left ankle, no bruising, swelling or abnormality was noted. The resident complained of pain and staff administered a physician prescribed pain medication to the resident for pain.

Nursing note dated 8/17/15 timed 11:36 A.M., recorded a facsimile sent to the resident ' s physician documenting right ankle pain. The resident reported, " " it feels like it ' s broken " .

The results of the physician ordered right ankle x-ray on 8/18/15 at 10:34 A.M. documented findings of an oblique (slanting) fracture (broken bone) to the right distal fibula (one of the two bones of the lower leg) with moderate amount of lateral ankle soft tissue edema (swelling).

On 8/18/15 at 10:24 P.M. physician orders directed staff to place an immobilizer on the resident ' s right ankle and to consult an orthopedic physician (doctor that specializes in bones).

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Review of the August 2015 medication administration record documented staff administered the pain medication Tramadol extended release, 100 milligrams on 8/16/15 at 10:54 P.M., 8/20/15 at 4:51 P.M. and 8/21 at 1:50 P.M. The medication record documented the resident received scheduled Tylenol extra strength 500 milligrams three times daily at 8:00 A.M., 12:00 P.M. and 5:00 P.M.

The facility provided investigation dated 8/24/15 documented direct care staff P failed to use a gait belt when he/she transferred the resident from a wheelchair to a stationary chair, and used a one to one pivot transfer. The facility staff member failed to transfer the resident with two staff members as care planned.

A statement 8/20/15, recorded direct care staff transferred the resident from a wheelchair to a stationary chair, when the resident yelped out in pain.

A statement on 8/21/15, documented licensed nursing staff J heard the resident say " ouch, my ankle " when transferred by direct care staff P. The resident began favoring the right ankle and not placing it on floor or using it. Licensed nursing staff J assessed the resident, found the right ankle to be symmetrical with left ankle, no bruising or swelling. The resident complained of pain and staff administered physician ordered pain medication, notified the responsible party and the director of nursing.

Observation on 9/17/15 at 1:30 P.M. revealed the resident moved about in the facility in a lightweight wheelchair and immobilizer on the right ankle.

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On 9/21/15 at 3:00 P.M. observation revealed direct care staff L and M pushed the resident in the wheelchair to the hall bathroom and then transferred the resident to toilet, using the sit-to-stand lift mechanical lift.

During an interview on 9/18/15 at 10:40 A.M. administrative nursing staff D reported staff administered physician ordered pain medication to the resident initially after the incident for his/her complaint of pain. The next morning after the incident, staff notified the resident ' s physician when the resident ' s ankle revealed bruising, swelling, and he/she complained of pain.

On 9/18/15 at 12:25 P.M., licensed nursing staff G reported the resident required two staff for transfers with the sit-to-stand mechanical lift.

On 9/18/15 at 1:40 P.M. direct care staff N reported two staff transferred the resident with the sit-to-stand mechanical lift both before after his/her ankle fracture.

On 9/21/15 at 10:10 A.M. administrative nursing staff D revealed direct care staff P was suspended for not using a gait belt and unsafe transfer of the resident and remained on suspension.

On 9/21/15 at 1:15 P.M. direct care staff O reported two staff always transfer the resident with a gait belt and pivot and watch the direction of his/her feet. Two staff also transferred the resident with the mechanical sit-to-stand lift when feeling weaker.

The facility policy Abuse, Neglect, and

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F 224	Continued From page 14 Exploitation dated 8/2012, recorded the definition of Neglect, as the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness and to ensure safety and well-being, or the failure of a caregiver or fiduciary to provide the goods or services that are necessary to maintain the health or safety of an elder. The Gait Belts Policy dated 6/2009 recorded gait belts were used to aid in transferring and ambulating all patients on fall precautions. All personnel were issued a gait belt for use in assisting appropriate residents and should have the gait belt with them at all times when on duty. The undated policy Minimal lift/safe patient handling and transfers policy recorded all patients were assessed upon admission and as needed for the appropriate and approved method of transfer based on the safe patient handling and transfers algorithm. Residents were transferred per the recommendation of this algorithm. The facility failed to provide safe transfers for this cognitively impaired dependent resident as care planned and resulted in an avoidable injury of a fractured right leg.	F 224		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: The facility identified a census of 26 residents.	F 281		

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Based on observation, interview, and record review the facility failed develop an initial care plan for resident #11 with interventions to direct care and failed to revise the initial plan of care with interventions to provide supervision to protect other residents from resident-to-resident sexual abuse, elopement, and falls.

Findings included:

- The facility readmitted resident #11 with the diagnosis of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure).

The admission Minimum Data Set Assessment (MDS) dated 8/19/15 recorded the resident with a Brief Interview for Mental Status (BIMS) of 7, which indicated severe cognitive impairment. The resident required supervision and set up with all activities of daily living, exhibited steady balance, used a walker for ambulation, and wandered daily. The resident experienced falls prior to admission and one fall after admission.

The Care Area Assessment (CAA) dated 8/29/15 for cognition recorded the resident ' s BIMS score of 7 and diagnosis of Alzheimer's disease. The resident wandered daily and almost continually while awake. During the review period, staff documented daily wandering on the behavior flow sheets. The nurse ' s notes recorded the resident exhibited sexually inappropriate behaviors.

The CAA for behaviors dated 8/29/15 documented the resident wandered throughout facility all day while awake, exit seeking. Staff documented sexually inappropriate behaviors in the nurses ' notes with a recent history of

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hypersexual (clinical diagnosis to describe extremely frequent or suddenly increased sexual urges or sexual activity) phases. During this review period, nursing staff met with the resident ' s family and discussed transferring him/her to senior behavioral health for medication review due to increased behaviors. The nurses notes documented that resident became very angry and threatened staff.

The elopement risk assessment dated 8/10/15 recorded a score of (11), and (16) on 8/16/15, both high risk for wandering.

Review of the initial plan of care dated 8/10/15 recorded check boxes of the assessment. The resident was cognitively impaired, hearing impaired, wore hearing aids, and did not understand the staff. The resident transferred with an assistive device, and independent with ambulation and locomotion. The resident was incontinent of bowel and bladder, received pain and anti-psychotic medications.

The physician admission history and physical dated 8/10/15 documented the resident readmitted after a 6-week trial living with his/her spouse in an assisted living facility. The resident continued to have anxiety and agitation and his/her cognition continued to decline with worsening speech abilities. The resident also became incontinent of urine, had 3 non-injury falls during this time. The resident had received Depo-Provera injection (hormone injection given to reduce sex drive) for hypersexual behavior.

Nursing note on 8/11/15 at 9:39 A.M. documented the resident was alert, confused, wandering and packed his/her belongings and headed toward

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his/her old room. Housekeeping staff redirected the resident, then the resident went to the old room and had incontinent bowel episode.

Nursing note dated 8/11/15 at 9:39 P.M. documented the resident alert, confused, and wandered most of the evening, often without his/her walker.

Nursing note dated 8/14/15 at 8:07 P.M. recorded staff notified the physician of wandering behaviors, increased anxiety, agitation, becoming combative with staff, and exit seeking.

Nursing note on 8/16/15 at 12:16 A.M. recorded the resident was up and down during the evening, and was exit seeking twice. Staff found the resident in another resident ' s room and redirected the resident back to his/her room and into bed.

Nursing note dated 8/16/15 at 10:33 P.M. documented a staff member found the resident in a [gender] resident ' s room touching the [gender] resident ' s breasts. Staff redirected the resident after some resistance, and then notified the director of nursing and physician.

Nursing note dated 8/17/15 at 10:07 P.M. documented direct care staff assisted the resident to bed at approx. 9:00 P.M. and at 9:45 P.M. found the resident on the floor beside his/her bed.

Nursing notes dated 8/18/15 at 12:41 A.M. staff found the resident up walking around in his/her room naked at 12:15 A.M.

Nursing notes dated 8/20/15 at 8:29 A.M.,

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recorded the resident experienced a very rough evening and night, confused and delusional, with nonstop pacing and exit seeking. The resident exhibited threatening behavior, raised hands as to get ready to strike [gender] aide, but restrained when told in a firm voice to stop. The resident pushed his/her walker very fast with an urgent concern look on his/her face. The resident was unable to sit still, diaphoretic and becoming tired and unsteady on feet. Unable to verbalize what he/she was trying to do. He/she became agitated and physical, hitting, grabbing, and yelling when [gender] staff approached. The resident had a cup of pop, threw it out on floor, and splashed up the floor in front of nursing station. The resident reported, "I was just trying to sprinkle it evenly". The resident ' s behavior had not slowed down or changed and night shift reported the resident did not sleep well and was up and down all night.

Nursing notes dated 8/20/15 at 3:03 P.M. documented throughout the afternoon, the resident continued to go to all doors to try to get out, became angry and threatening. The staff continued to redirect the resident with minimal results. The resident threatened to throw the nurse out the door, had lifted his/her hand up in the air as if to hit a [gender] staff, with a very angry face and harder to redirect.

Social notes dated 8/20/15 at 4:31 P.M. documented calls to behavioral health units. Staff anticipated a transfer to a behavioral unit on 8/21/15.

Nursing note dated 8/21/15 at 1:19 A.M. documented staff found the resident exiting out of a [gender] peers (resident #17) room and redirected the resident back to his/her room.

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When asked, resident #17, reported resident #11 walked in and touched his/her shoulder, and he/she yelled at him/her to leave, and he/she left the room. Staff reminded the resident that he/she cannot go into another resident ' s room. Nursing staff sent a facsimile to the physician and notified the director of nursing.

Review of the incomplete facility investigation dated 8/21/15 documented a licensed nursing staff witnessed the resident leaving resident #17 ' s room and shutting the door. Resident #17 reported resident #11 touched him/her on the shoulder and he/she was startled and yelled out in fright. Resident #17 stated, " He/she scared me. " Staff redirected the resident back to his/her room across the hallway from resident #17.

Nursing note dated 8/21/15 timed 1:39 P.M. documented the facility transferred the resident to an acute hospital behavior unit.

During an interview on 9/17/15 at 3:50 P.M. administrative nursing staff D reported staff completed the residents initial care plan in the computer under assessments.

The interim plan of care lacked any interventions to direct staff for managing the resident ' s behaviors, elopement attempts, or fall prevention.

On 9/18/15 at 12:35 P.M. licensed nursing staff G revealed the resident walked independently with a walker, had a lot of anxiety, required cueing and staff monitored the resident ' s location hourly due to the fall and elopement risk.

On 9/18/15 at 1:20 P.M. direct care staff Q reported the resident was confused, ambulated

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F 281	Continued From page 20 independently with a walker and went in and out of resident rooms. Direct care staff Q revealed when the facility readmitted the resident, He/she was placed on a different hall from the first admission, which seemed to confuse the resident. On 9/18/15 at 1:40 P.M. direct care staff N reported the resident was an elopement risk, wandered all the time, and would go in and out of other resident rooms. Direct care staff N revealed on one resident on C-hall (resident #13 ' s hall) could complain. "The Clinical Guidelines from American Health Information Management Association, Long Term Care Health Information and Documentation Guidelines, September 2001 documented Admission/Interim Care Plan - upon admission, an "initial care plan should be developed to carry through until the resident's comprehensive assessment and care plan have been developed. The care plan should address the primary reason for admission and treatment and the resident's most immediate care needs." The facility failed to develop an admission care plan with interventions for the resident ' s daily wandering, resident-to-resident abuse, behaviors, and fall prevention.	F 281		
{F 323} SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	{F 323}		

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This REQUIREMENT is not met as evidenced by:
The facility identified a census of 26 residents. Based on observation, interview, and record review, the facility failed to ensure supervision, assistive devices, and effective interventions to prevent falls for 4 of 4 cognitively impaired dependent residents (#12, 14, 15, and 16). The facility also failed to provide supervision and assistive devices to prevent the cognitively impaired resident (#12) from leaving the long-term care unit without staff knowledge.

Findings included:

- The clinical face sheet recorded the facility admitted resident #16 on 6/14/13 with diagnosis that included senile dementia (progressive mental disorder characterized by failing memory, confusion) with delusional (untrue persistent belief or perception held by a person although evidence shows it was untrue) features, psychosis (any major mental disorder characterized by a gross impairment in reality testing), and schizophrenia (psychotic disorder characterized by gross distortion of reality, disturbance of language and communication and fragmentation of thought).

The annual Minimum Data Set Assessment dated 6/28/15 recorded the resident with a Brief Interview for Mental Status (BIMS) score of 3, which indicated severely impaired cognition. The resident wandered daily, which placed the resident at significant risk of getting to a

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potentially dangerous place and required supervision with transfers, ambulation, and experienced falls since the previous assessment. The resident exhibited steady balance, no functional loss of range of motion, and used no mobility device. The resident assessed with impaired vision wore glasses.

The Care Area Assessment (CAAs) for behaviors dated 7/11/15 documented the resident wandered almost continually while awake.

The CAA for falls dated 7/11/15 documented the resident experienced a fall with injury on 6/9/15.

The urinary CAA dated 7/11/15 recorded the resident had increased episodes of urinary and bowel incontinence as documented on activity of daily living flow sheets, as an expected outcome from the disease process.

The Fall Assessments dated 6/24/15, 8/5/15, 8/29/15 and 9/14/15, recorded scores of 55-65, which placed the resident at high risk for falls.

The mobility assessment dated 6/26/15, directed the resident required assistance of one person for transfers.

The resident ' s care plan for activities of daily living (ADLs) dated 7/17/15, documented the resident with a self-care deficit related to dementia and confusion and staff reminded the resident, when in his/her room, how to use the call light and stressed the importance of reminders as sometimes the resident forgot how the call light worked.

The resident ' s plan of care for fall prevention

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dated 7/17/15 directed staff to encourage the resident to wear socks and shoes while ambulating, nonslip footwear and have a good light on when it is dark. Staff assisted with ambulation as needed and checks on the resident hourly to prevent falls due to wandering. Staff encouraged the resident to slow down and observe surroundings.

Nursing note dated 8/5/15 timed 5:59 A.M. recorded staff found the resident on the floor at 5:40 A.M. when the resident ' s roommate used the call light to inform the staff he/she had fallen. Staff found the resident sitting in the bathroom doorway on his/her buttocks, in a puddle of urine, with the incontinence brief halfway down. It appeared the resident slipped and fell.

Nursing note dated 8/5/15 at 6:16 A.M. recorded the intervention of a 72-hour bowel and bladder-retraining program.

Review of the facility provided incomplete investigation dated 8/5/15 documented unknown staff toileted the resident at 2:00 A.M. and thirty minutes prior to the fall staff observed the resident in bed. The investigation recorded the resident with severe dementia and wandered throughout the facility.

Nursing note dated 8/5/15 timed 10:16 P.M. documented the resident was alert to name only.

Nursing note dated 8/20/15 at 6:50 P.M. recorded staff found the resident on the floor in the dining room, sitting on his/her buttocks. The resident stated, "I fell." Staff asked the resident if he/she hit his/her head, and the resident replied, "Yes." Nursing assessed the resident with a

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quarter-sized red area on the back of his/her head and implemented neurological checks. Staff observed the resident wore only one shoe and would make sure he/she always had proper footwear on when up ambulating.

Review of the facility provided incomplete investigation dated 8/20/15 documented the confused resident shuffles his/her feet when walking and removed his/her shoes. The intervention in response to the accident repeated, " To ensure proper footwear was in place when the resident was up ambulating."

Nursing notes dated 8/23/15 at 12:40 P.M. documented the resident wandered this afternoon, carrying a blanket, entering other resident rooms, down to assisting living, chanting, " I need a nurse so I can go home! " Nursing staff redirected the resident.

Nursing note dated 8/29/15 at 11:27 P.M. documented the resident got up out of a recliner, took a few steps, fell, and ended up on his/her back. Nursing staff assessed the resident with no redness, bruising, or swelling.

Review of the facility provided incomplete investigation dated 8/29/15 documented an unknown staff observed the resident in the recliner 5 minutes prior to finding the resident on the floor. The resident was alert to person only, had poor eyesight, unstable on his/her feet at times, and possibly needed toileting. The new intervention implemented directed staff to toilet the resident every hour.

Nursing note dated 8/30/15 at 12:24 P.M. documented the resident ' s verbal comments to

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fear of falling stating, " watch out " and " don ' t let me fall again".

Nursing note dated 8/30/15 at 5:39 A.M. documented the resident complained of his/her head hurting. Staff administered the physician ordered Tylenol for the resident ' s headache.

Nursing note dated 9/6/15 at 2:14 A.M. documented the resident got up out of bed this evening, stood at nursing station repeatedly stating, " I have to go " . When asked where the resident wanted to go, he/she stated, " Out of here " . Staff attempted to redirect the resident without success.

Nursing note dated 9/14/15 at 4:24 P.M. documented the resident wandered in the dining room, when direct care staff reported to the nurse the resident fell. A direct care staff member reported had his/her back turned but heard the resident hit floor. Another (unidentified) resident reported the resident bent over to pick something up and fell. The resident also stated he/she was picking something up, a radio, something for mother, etcetera. There was nothing observed on the floor.

Review of the facility incomplete investigation documented another (unidentified) resident observed the resident fall on his/her face, and direct care staff heard the resident fall. Staff assessed the resident with bruising and swelling to the face, eyes, and forehead.
The investigation recorded the fall intervention that directed staff to monitor the resident's behavior closely when wandering.

Nursing notes dated 9/15/15 at 9:44 A.M. staff

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assessed the resident with the right eyelid dark purple with thin purple areas under the eye, an abraded area on the right forehead. The resident complained of left jaw pain and nose pain. The resident's nose was swollen and he/she had slight difficulty opening the right eye due to edema (swelling with an accumulation of fluid).

Nursing note dated 9/15/15 at 3:38 P.M. documented the physician orders for staff to take the resident to radiology at 1:30 P.M.

Nursing note dated 9/16/15 at 2:16 P.M. recorded the results of the resident's facial x-ray without any fracture. The note advised to do a CT scan if the resident presented with any clinical concerns. Nursing staff faxed the primary care physician with the results.

Nursing note dated 9/17/15 at 4:29 A.M. recorded the resident was alert and oriented to name only, able to ambulate without assistance and a slow gait, and increased systolic blood pressure. Both resident eyes were blackened with the fall on 9/14/15, the right eye much more bruised than the left, nose swollen and abrasion on the right superior forehead. The resident complained of a headache above the right eye at 4:37 A.M. and staff administered the physician ordered Tylenol 500 milligrams for pain.

The resident bowel and bladder retraining program observation dated 8/8/15, 8/9/15, and 8/10/15, included approximately 25% complete documentation, and lacked hourly timed observations and documentation.

Observation on 9/17/15 at 1:30 P.M. revealed the resident, with a black right eye, quietly sat in a

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chair in the living room, without glasses, and wore slippers.

On 9/18/15 at 12:35 pm, the resident, without glasses, wore slippers and slowly ambulated in the halls without assistance.

On 9/18/15 at 3:45 P.M., observation revealed the resident, without glasses, constantly walking the walls, then stops at a doorway, bent over and ran his/her fingers on the floor as if to pick something up off the floor. Observation revealed nothing on the floor.

Observation on 9/21/15 at 10:00 A.M. the resident sat in chair in living room, eyes closed, holding a blanket.

On 9/21/15 at 10:15 A.M. the resident, without glasses, stood up without staff and slowly walked with shuffling feet and house shoes without backs over the heels, dragging the blanket down the hall.

On 9/21/15 at10:45 A.M., after toileting the resident, direct care staff brought the resident out to the living room for the dance exercise activity, wearing house shoes. The resident participated in the activity, dancing to the music.

On 9/21/15 at 11:17 A.M. approximately 3 to 4 minutes after the conclusion of the activity, the resident, without glasses, stood up from the chair and said, " I gotta go! " and began slowly pacing in the living room, wore house shoes, and repeating, " I gotta go, where can I go?. " The resident approached licensed nursing staff G and asked, " Where do I go? " Licensed nursing staff directed the resident to a chair at the dining room

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table.

On 9/21/15 at 12:11 P.M. the resident continued eating the noon meal.

Observation on 9/21/15 at 12:16 P.M. revealed the resident, without glasses, stood up from the dining table after eating and asked direct care staff R, who was assisting a dependent resident to eat at the same table, what to do. Direct care staff R told the resident he/she was helping another resident with the noon meal right now. The resident slowly shuffled from the dining room around the living room area, to licensed nursing staff H, and asked the staff about going to the bathroom. Licensed nursing staff H took the resident's hand and walked him/her to the bathroom. A few minutes later, the resident and licensed nursing staff H, carrying the residents non-skid shoes, returned to the living room, the resident in stocking feet (without nonskid). Licensed nursing staff H assisted the resident to sit in a straight-backed chair and placed the shoes on the resident's feet.

Observation revealed staff failed to toilet the resident each hour as care planned on 8/29/15.

Observation revealed staff ambulated with the resident in the hall without non-skid soled shoes or socks.

On 9/21/14 at 12:37 P.M. the resident without glasses, walked out of dining room and asked staff what he/she should do. The facility staff passed by the resident, and told him/her, " they are busy " . At this time, a cognitively impaired resident #10, seated in a wheelchair in the area asked the resident, " Do you want me to go with

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you? " The resident continued with a shuffling walk repeating, " I need to go home. "

On 9/21/15 at 12:46 P.M. the resident briefly sat in a chair in the resident café.

During an interview on 9/18/15 at 1:20 P.M. direct care staff Q reported the resident required assistance with dressing, toileting, and to prevent falls. Staff observed the resident ' s gait for steadiness and reported the resident did not use the call light.

On 9/18/15 at 12:35 P.M. licensed nursing staff G reported the staff assisted the resident with toileting every 2 hours. The resident was on fall precautions and staff used redirection and 1:1 when wandering. Licensed nursing staff G reported sometimes the resident might tell staff he/she cannot find the bathroom.

On 9/21/15 at 10:10 A.M. administrative nursing staff D reported staff used the (incomplete) 72-hour toileting diary to determine the resident ' s toileting needs and staff toileted the resident every hour. Staff observed the resident ' s gait and when unsteady, provided assistance with ambulation, and do hourly safety checks on the residents at risk for falls and elopement.

On 9/21/15 at 1:15 P.M. direct care staff O reported staff assisted the resident with toileting every 2 hours, unless the resident asked sooner. The staff used distraction to curb the resident ' s wandering and encourage the resident to sit and wait for family to visit. When the resident was unsteady walking, staff assisted him/her.

The facility provided undated Event Reporting

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Checklist directed to use the form as a guide and use good nursing judgment for the follow-through of all events. Staff immediately put interventions in place to prevent repeated falls, updated the care plan with the date, and new fall prevention intervention.

The facility provided policy Falls, Reporting, Investigation, and Prevention dated October 2010, provided a procedure with guidelines for assessing a resident after a fall and to assist the staff in identifying the causes of the fall. The policy directed staff to review the resident ' s care plan to assess for any special needs of the resident. Within 24-hours of a fall, the nursing staff would begin to try to identify possible or likely causes of the incident.

Review of the facility provided incomplete investigations lacked evidence of any witnesses of the observed events or the root causative factors of each fall.

The facility failed to provide supervision, assistive devices, and effective interventions for this cognitive impaired resident assessed as a high fall risk to prevent repeated falls that resulted in a facial injury of bruising of the eyes and swelling of the resident's nose.

- The facility admitted resident #14 on 10/2/14 with diagnosis in the electronic health record that included dementia (progressive mental disorder characterized by failing memory, confusion), and muscle weakness.

The admission Minimum Data Set Assessment (MDS) dated 10/11/14 documented the resident

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with a Brief Interview for Mental Status (BIMS) of 4, which identified the resident with severe cognitive impairment, and required extensive assistance from staff with transfers. The resident experienced two non-injury falls since admission.

The Care Area Assessment for falls dated 10/16/14 recorded the resident was non-ambulatory, propelled him/herself in a wheelchair, unsteady on his/her feet, and attempted self-transfers that resulted in falls. The resident had not attempted to exit, however asked about leaving and was forgetful at home.

The resident mobility assessment dated 7/11/15 recorded the resident required assistance of one person for transfers.

The quarterly MDS dated 7/14/15 documented the resident with a BIMS score of 4 and requires extensive assistance from staff with transfers, and experienced an injury fall since the last assessment.

The Fall Assessment dated 7/16/15 and 8/17/15 recorded a score of (75) which placed the resident at high risk for falls.

The resident's plan of care for activities of daily living dated 8/3/15 documented the resident required assistance with dressing, grooming, and picking his/her clothing. The resident had limited physical mobility related to a history of fractured hip, a history of T-11 compression fracture (when forced together bone surfaces caused a bone to break) and new T-11 compression fracture. The resident was able to self- propel in the wheelchair throughout facility, however required staff assistance to transfer to and from the bed and

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wheelchair. The resident required stand by assistance of one staff for locomotion using the walker. Staff monitored the resident ' s location every hour on the elopement roster.

The resident's plan of care for falls dated 8/3/15 documented the resident with an unsteady gait and poor balance. The plan directed staff to place the resident's call light within reach, and encourage resident to use it for assistance. Staff needed to promptly respond to all requests for assistance. Staff provided a reachable call light, bed in low position at night, the wheelchair within reach, and pressure alarm at all times. The pressure alarm alerted across the pager system when triggered. Staff followed the facility fall protocol. Staff instructed the resident not to reach for items on the floor, but ask for assistance. Additional intervention on 8/17/15, move the resident ' s commode by the bed at night from the bathroom and place non-skid socks on the resident at night.

Nursing notes dated 4/26/15 timed 7:36 P.M. documented staff found the resident on the floor in the doorway of his/her bedroom laying on the right side. The resident reported he/she hit his/her head. Staff assessed the resident with an open area on the bottom lip and the resident complained of left shoulder pain. Staff notified the physician and obtained orders for a left shoulder x-ray.

Nursing note on 4/27/15 at 10:30 A.M. recorded the resident's x-ray results of a non-displaced impaction fracture of the left upper clavicle.

Nursing note on 7/16/15 at approximately 9:00 A.M. documented staff found the resident lying on

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his/her back on the bedroom floor with the bed alarm sounding. The resident reported he/she was trying to get up. The resident had not been toileted since 5:30 A.M. and was probably attempting to toilet him/herself.

Nursing note dated 8/17/15 at 1:53 P.M. documented staff found the barefoot resident sitting on the floor between the bed and air-conditioning unit in a puddle of urine this morning. Staff assessed the resident with multiple skin tears to right hand, left wrist, let knee, an abrasion to the left side of his/her face, and a bruise to the left side of the resident's upper lip. Staff documented the intervention to give the resident non-skid socks to wear at night and moved the commode out of the bathroom and next to the resident's bed to prevent further injury.

Review of the facility incomplete investigation dated 8/17/15 documented unidentified staff observed the resident at 6:00 A.M. in bed. At 7:00 A.M., the resident's personal safety alarm sounded and unidentified staff found the resident on the floor. Staff found the resident faced away from the restroom. The resident was unable to ambulate, unsteady gait and balance, used a wheelchair for mobility, and needed toileting. Staff assessed the resident with a 1 centimeter by 1 centimeter abrasion to the left side of his/her face; 1 centimeter by 1 centimeter by 0.5 centimeter raised bruise on the left upper lip; 1 centimeter skin tear to the outer right thumb; 1 centimeter v-shaped skin tear to the left inner wrist; 2 centimeter v-shaped skin tear to the left knee; and 1 centimeter skin tear to the left knee. The investigation documented the interventions of non-skid socks at night and a commode to bedside at night.

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The facility investigation dated 8/21/15, reported to the state agency recorded the resident would remain on hourly safety monitoring, would continue to use the personal body alarm, at night the bedside commode would be moved to beside and staff would assist the resident with non-skid socks at night.

Nursing note dated 8/18/15 at 7:45 P.M. documented the resident ambulating in the wheelchair, which was normal for the resident because he/she was a fall risk with an unsteady gait.

Nursing note dated 8/25/15 at 8:20 P.M. documented at 7:50 P.M. direct care staff reported the resident with a skin tear, 5 centimeters by 3 centimeters c-shaped skin tear on the right arm below the elbow. Staff reported the resident bumped his/her elbow on a side rail with sharp edges and no protective cap. Nursing staff cleaned the wound and applied Steri-strips to and a dressing.

Observation on 9/18/15 at 7:55 A.M. revealed the resident slept in a low bed with a half rail up on the outside of the bed and a bedside commode on the other side of the bed.

On 9/18/15 at 11:10 A.M. the resident sat rocking in his/her wheelchair in dining room with a personal alarm attached to the wheelchair.

On 8/18/15 at statement by direct care staff N reported staff heard the personal body alarm sounding and found the resident on the floor in a puddle of urine, with blood hands from the fall.

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On 8/21/15 at statement by licensed nursing staff G recorded staff found the resident on the floor in a puddle of urine with multiple skin tears.

On 9/18/15 at 1:20 P.M. direct care staff Q reported the resident was a fall risk and required help with all activities of daily living. The resident required contact guard assistance from staff for transfers and staff checked on the resident during rounds of the hall.

On 9/18/15 at 12:35 P.M. licensed nursing staff G revealed the resident was a fall risk and required one-person assist. The resident did not use the call light and staff performed hourly checks for elopement risk and fall risk.

On 9/21/15 at 1:15 P.M., direct care staff O reported the resident required assistance with clothing for dressing, toileting, and transfers. The resident sometimes asked for assistance with toileting, but not using her call light. He/she has a personal pressure alarm to alert staff. One staff member transfers the resident to the commode with a gait belt; however, sometimes the resident goes without assistance.

The facility provided policy Falls, Reporting, Investigation, and Prevention dated October 2010, provided a procedure with guidelines for assessing a resident after a fall and to assist the staff in identifying the causes of the fall. The policy directed staff to review the resident ' s care plan to assess for any special needs of the resident. Within 24-hours of a fall, the nursing staff would begin to try to identify possible or likely causes of the incident.

The facility failed to provider supervision,

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assistive devices, and effective interventions for this cognitively impaired resident assessed at high risk for falls, with repeated falls in the facility.

- The clinical face sheet recorded the facility admitted resident #15 on 4/5/14 with documented diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure) and dementia (progressive mental disorder characterized by failing memory, confusion) with behavioral disturbance.

The annual Minimum Data Set Assessment (MDS) dated 4/19/15 recorded the resident with a BIMS (Brief Interview for Mental Status) score of 00, which identified the resident with severe cognitive impairment and required extensive assistance from two or more staff for all activities of daily living except for eating. The resident exhibited unsteady balance and was unable to stabilize with assistance for turning and transfers. The resident experienced 2 or more non-injury falls and 1 fall with a major injury since the previous assessment.

The Care Area Assessment (CAAs) dated 4/26/15 for falls documented the resident had 9 falls without injury and 1 fall with a major injury since the previous MDS. The resident had poor safety awareness, unsteady gait, walks with a walker and while the location of the falls were random, falls usually occured when the resident was ambulating.

The quarterly MDS dated 7/18/15 documented the resident with a BIMS score of 1, which indicated the resident with severe cognitive impairment. The resident required extensive

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assistance from staff for activities of daily living, exhibited unsteady balance, only able to stabilize with staff assistance, and experienced 2 or more non-injury falls since last assessment.

Review of the Fall Assessments dated 7/30/15, 8/8/15, 8/27/15, 8/29/15, 8/30/15, and 9/10/15 scored 55-90, identified the resident at high risk for falls.

The resident's mobility assessment dated 7/18/15 documented the resident required a 2 person transfer.

The plan of care dated 4/29/15 documented the resident at high risk for falls related to an unsteady gait and forgetfulness. The plan of care directed staff to:
1) Provide one-to-one activities.
2) Encourage the resident to bend at the waist while attempting to set.
3) Anticipate and meet the resident needs.
4) Place the call light within reach and encourage the resident to use it.
5) Staff promptly responded to all the resident ' s requests for assistance.
6) Educated the resident/family/caregivers about the safety reminders and what to do if a fall occurs.
7) Staff ensured the resident wore appropriate footwear when mobilizing in the wheelchair and non-skid socks when in bed and shoes are out of sight.
8) Staff followed the facility fall protocol, frequently checked on the resident, and performed hourly monitoring.
9) Staff observed the resident first thing at the beginning of the shift, if awake offered restroom assistance.

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10) Keep the resident in view of staff while out of bed and room.
11) Invite the resident to sit/remain in the central area of the building as much as possible for more frequent safety checks.
12) The resident wore a personal body alarm (PBA) while in bed, in his/her room unattended or in a chair that is out of sight from the nursing station.
13) Ensured the resident asked for assistance when getting up or sitting down in the dining room.
14) Staff would continue to remind the resident and cue to ask for help while in the recliner.
15) Staff will frequently check on the resident while in the recliner and ask the resident if he/she needed help.
16) The resident will wear briefs with elastic sides, as briefs with taped sides fall down, causing the resident to stumble.
17) Staff asked the resident after supper if he/she was ready for bed to reduce falls or injuries at bedtime.
18) The resident used an electronic alarm that was provided by his/her family. Staff ensured the device was in place as needed.
19) Staff toileted the resident after each meal and every 2 hours.
20) Staff asked the resident if he needed to use the toilet to prevent the resident from trying to toilet him/herself.
21) Staff removed the unoccupied wheelchair from the sitting area by the fireplace to assure the resident would not mistake the wheelchair for a recliner and attempt to sit down.
22) When the resident was in the dining room, staff made sure the resident gets into and out of the dining room chair safely, with assistance.
23) For no apparent acute injury, determine and

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address causative factors of the fall.
24) Lay the resident down between meals to rest after toileting.
25) Pharmacy consult to evaluate medications.
Additional interventions included:
5/17/15, The resident leaned to the right, tipped him/herself sideways while in the wheelchair towards right to the floor. Physical therapy to assess the resident post hospitalization.
5/25/15, Fall mat to be placed on floor next to the resident's bed.
6/2/15 Ask the resident after meals if he/she would like to be placed in a different chair besides the wheelchair.
8/12/15, Resident to be laid down in between meals to rest. Do not leave resident up in wheelchair after meals. (repeated intervention)
8/27/15, Ensure appropriate foot wear when mobilizing in wheelchair. Ensure resident has non-skid docks on when in bed and does are out of sight. (repeated intervention)
8/29/15, Apply the PBA (personal body alarm) on at all times.
9/10/15, Place alarm on opposite side of dominate hand out of reach so he/she cannot remove the alarm.

Nursing note dated 6/8/15 at 8:57 A.M. documented staff found the resident on the floor by the bed laying on his/her right side. The resident 's night-gown on bed with PBA attached. The resident removed prior to getting up. When asked what he/she was doing on the floor, the resident stated, "I fell".

Nursing note dated 7/24/15 at 11:14 A.M. recorded at approximately 10:30 A.M. staff discovered the resident lying on his/her fall mat next to the bed with wet bedding. The resident

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stated, "I slipped. Can you help me up? We probably need 2 or 3 people." The nursing assessment revealed an approximately 3 inch red area over the residents right shoulder. Staff assisted the resident up and dressed for breakfast.

Nursing note dated 7/30/15 at 5:19 P.M. documented at 4:45 P.M., staff in the television area, witnessed the resident sliding out of the wheelchair onto his/her right side on the floor. The added intervention to the resident's care plan, directed staff to lay the resident down between meals to rest after toileting.

Nursing note dated 8/8/15 at 7:13 P.M., recorded staff found the resident on his/her right side lying on floor to the south part of room by a chair. Nursing assessed the resident without injury.

Nursing note dated 8/25/15 timed 1:57 P.M. documented a " late entry " for an incident which occurred on 8/15/15. Staff observed the resident roll out of the wheelchair onto his/her right side on the floor and received a skin tear to the back of the right hand.

Nursing note dated 8/23/15 at 2:25 P.M., recorded staff reported the resident with a 1 centimeter skin tear on the right hand and 3 centimeter by 2 centimeter abrasion on the right outer knee from the last fall.

Nursing note dated 8/27/15 at 6:17 P.M. staff observed the resident lean forward in his/her wheelchair and fall to the floor on his/her right side.

The facility provided incomplete fall investigation

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dated 8/27/15 at 6 pm, recorded staff found the resident in front of the nursing station in wheelchair and (unknown) nurse witnessed the resident leaning forward in the wheelchair. Resident lost his/her balance, and fell forward onto the floor, on his/her right side. The resident had unsteady gait/balance, confused, and was alert to person only. The investigation repeated the intervention for staff not leave resident unattended in wheelchair after meals.

Nursing note dated 8/29/15 at 5:51 P.M. documented staff witnessed the resident stand up from the wheelchair, fall, and land on his/her right side.

The incomplete fall investigation dated 8/29/15 timed 5:40 P.M., documented an (unknown) witness observed the resident attempt to stand up and lose his/her balance, and fall to the right side. The investigation documented the resident was unable to stand on his/her own, had progressing dementia. The investigation repeated the intervention do not leave resident unattended in the wheelchair.

Nursing note dated 8/30/15 at 1:38 P.M. documented at approximately 1:15 P.M. staff found the resident lying on floor in the hallway of a doorway lying face down. Staff had toileted the resident within the past 15 minutes and the resident was sitting in the wheelchair in hallway. Staff assessed the resident with a 1.2 centimeter by 0.2 centimeter abrasion to the right side of the head. Staff transferred the resident into recliner.

The facility staff failed to keep the resident in view of staff or transfer the resident out of the wheelchair to prevent the fall.

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The facility fall investigation dated 8/30/15 timed 1:15 P.M. recorded the resident with an unsteady gait, balance, and decreased mobility. The investigation repeated the intervention do not leave the resident unattended in the wheelchair.

Nursing note dated 9/10/15 at 4:49 A.M. documented staff found the resident at 4:00 A.M. on the floor mat next to the bed.

The facility incomplete investigation dated 9/10/15 documented at 4:00 A.M. the resident was ambulating, unable to ambulate and staff found the resident on the floor by the bed on the floor mat. The investigation documented the resident attempted to get up on his/her own and staff last toileted the resident at 1:45 A.M. The investigation failed to document if the resident wore the personal alarm, or if the alarm sounded.The investigation recorded the intervention to place the resident in the recliner near the nursing station. This investigation documented the resident with repeated falls on 7/24/15, 7/30/15, 8/27/15, 8/29/15, 8/30/15, and 9/10/15.

Observation on 9/18/15 at 12:30 P.M. revealed direct care staff N pushed the resident in a wheelchair from the dining room down the hallway and left the resident seated alone in the hall until 1 P.M.

On 9/18/15 at 1:00 P.M. direct care staff N and Q stood the resident without a gait belt and with four to five shuffling steps transferred the resident from the wheelchair to a recliner in the living room, and placed the personal alarm on the recliner.

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Observation revealed facility staff failed to use a gait belt with the transfer as directed in the facility policy.

On 9/18/15 at 2:45 P.M. licensed nursing staff I and direct care staff M assisted the resident to toilet with the sit-to-stand mechanical lift.

On 9/18/15 at 3:00 P.M. licensed nursing staff K and direct care staff M stood the resident, holding the resident ' s arms, from the wheelchair with shuffling steps, to the recliner, as licensed nursing staff I pulled from the back of the resident to bend the resident at the waist to sit in the chair. Observation revealed facility staff failed to use a gait belt with the transfer as directed in the facility policy.

On 9/21/15 at 1:20 P.M. the resident sat in a recliner in the television room, with the right foot off the recliner footrest, tipped the recliner forward, and stopped the recliner from dumping the resident onto the floor with the right foot. The personal alarm remained attached to the resident and chair and did not sound. Direct care staff O went to the resident and righted the chair.

On 9/18/15 at 1:20 P.M. direct care staff Q reported two staff transferred the resident with a gait belt. Staff transferred the resident to a recliner from the wheelchair, and were not to leave the resident up in the wheelchair unattended.

On 9/18/15 at 12:35 P.M. licensed nursing staff reported two staff transferred the resident with a gait belt.

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On 9/21/15 at 1:15 P.M. direct care staff O reported the resident was at risk for falls. The resident did not use the call light, had a personal alarm, fall mat, and two staff used a gait belt when they transferred the resident.

The facility provided Gait Belt policy dated June 2009, purpose recorded the promotion of ambulation activity for residents on fall precautions, by providing increased security for the resident and staff and/or to provide security for transfers. Staff used gait belt to aid in the transferring and ambulating of all residents on fall precautions.

The facility provided undated Event Reporting Checklist directed to use the form as a guide and use good nursing judgment for the follow-through of all events. Staff immediately put interventions in place to prevent repeated falls, updated the care plan with the date, and new fall prevention intervention.

The facility provided policy Falls, Reporting, Investigation, and Prevention dated October 2010, provided a procedure with guidelines for assessing a resident after a fall and to assist the staff in identifying the causes of the fall. The policy directed staff to review the resident ' s care plan to assess for any special needs of the resident. Within 24-hours of a fall, the nursing staff would begin to try to identify possible or likely causes of the incident.

Review of the facility provided incomplete investigations lacked evidence of any witnesses of the observed events or the root causative factors of each fall.

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The facility failed to provide supervision, assistive devices, and effective interventions for this cognitive impaired resident assessed as a high fall risk, with 9 falls in the last three months, to prevent falls that resulted in repeated skin tears.

- The clinical face sheet recorded the facility admitted resident #12 on 9/26/13 with diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure, psychosis (any major mental disorder characterized by a gross impairment in reality testing), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and secondary parkinsonism (slowly progressive neurologic disorder characterized by resting remor, rolling the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).

The annual Minimum Data Set Assessment dated 1/21/15 documented the resident with a Brief Interview for Mental Status (BIMS) score of 00, which identified the resident with severe cognitive impairment. The resident wandered daily, experienced delusions, and required supervision of one staff for locomotion. The resident exhibited unsteady balance, only able to stabilize with staff assistance, and experienced two or more non-injury and one minor injury fall since the previous assessment.

Review of the Care Area Assessment (CAAs) dated 1/31/15 for cognition, documented the resident had poor short and long-term memory recall, poor safety awareness and a decreased ability to care for him/herself.

CAAS for falls dated 1/31/15 documented the

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resident with five falls since the previous assessment period. The resident wandered throughout the facility in a wheelchair. A physical therapy referral dated December 2015 recorded the resident was unable to follow commands to participate in therapy at that time.

The quarterly MDS dated 7/24/15 recorded the resident with a BIMS score of 1, which identified the resident with severe cognitive impairment. The resident wandered daily and required extensive assistance from two staff with all activities of daily living except eating. The resident exhibited unsteady balance and only able to stabilize with staff assistance, used a wheelchair for locomotion and experienced two or more non-injury falls since the previous assessment.

Review of the Fall Assessment dated 7/18/15, 8/8/15, 8/28/15, 8/29/15, and 9/7/15 recorded a total score of (55 to 75), which placed the resident at high risk for falls.

Review of the resident mobility assessment dated 7/18/15, documented the resident required assistance of 2 staff for transfers.

The plan of care revised dated 8/27/15 documented the resident was at risk for injury falls related to his/her decline in cognition and unsafe self-transfers. The plan of care directed staff to:
*Place alarm at all times. Ensure the pressure alarm cord was out of reach and the resident could not remove it.
*After supper, staff would toilet the resident, then place the resident in a recliner as the resident appeared to rest well at that location.

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*Complete fall risk assessment per facility protocol. Consider med regime with assessment.
*Decreased time in room. Provide care needed in room and redirect to activities out of room and in staff sight.
*Encourage resident to await assistance for transfers.
*Encourage resident not to go down D-wing, redirect.
*Ensure assistive equipment was used appropriately.
*Ensure call light is within reach when in room unsupervised. Encourage to call for assist with transfers.
*If new onset falls, assess for abnormalities, symptoms of infection and check vitals.
*The resident required a medication evaluation, had increased anxiety and non-stop movement, trying to get out exits. This contributes to placing self on floor or falling.
*Observe for signs and symptoms of anemia or fluid volume deficit and update physician and responsible party as indicated.
*Observe the resident for balance and mobility issues.
*Offer the resident the restroom before and after meals, every 1-2 hours between meals and as needed (PRN) when restless.
*Offer the resident assistance to lay down after the noon meal, added 2/16/15.
*Padding to outside of the bed rail for resident safety.
*Personal alarm alert system was placed out of reach of resident to ensure resident cannot unplug him/herself.
*Personal alarm while in bed and in wheelchair.
*Remind the resident during cares to wear his/her shoes when out of bed, at all times.
*Request appointment with physician for

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medication review related to increase of anxiety and aggression.
*When resident ' s spouse was not visible to the resident for an extended time, assure resident of his/her location.
Interventions added:
On 8/8/15, administer antibiotic until completed to assure urinary tract infection does not play a role in the fall.
On 8/27/15 increase monitoring of resident to promote safety. Log on resident monitoring tool.
On 8/28/15 Staff ask the resident if he/she would like to lay down in bed after lunch to prevent him/her from trying to put him/herself to bed. (repeated intervention)

The facility identified the resident with recent falls on 8/28, 8/29, and 9/7.)

The resident 's plan of care for self-care-deficit dated 8/27/15 directed the resident required assistance of one staff and gait belt for transfers.

Nursing note dated 7/22/15 at 10:32 A.M. recorded the resident was alert to him/herself, and wheeled through the facility in the wheelchair on a daily basis.

Nursing note dated 7/26/15 at 6:44 P.M. documented a unidentified resident notified staff the resident was on the floor.

Nursing note dated 7/29/15 at 8:54 A.M., documented the resident wandered in the facility and had gotten up multiple times and attempted to walk.

Nursing note dated 8/8/15 at 8:06 P.M. recorded staff witnessed the resident, out of the

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wheelchair, hold onto handrail and then sat on the floor.

Nursing note dated 8/28/15 at 3:32 P.M. recorded a laundry staff witnessed the resident attempting to transfer, when he/she fell to the floor. The resident ' s personal body alarm sounded, staff responded, but the resident was already on the floor. The resident was attempting to go to bed, hit the left shoulder on the floor and then hit the left side of his/her head on the floor.

The facility provided incomplete investigation dated 8/28/15 timed 1:20 P.M. recorded (unidentified) laundry staff witnessed the resident attempt to self-transfer from a wheelchair and fell forward onto the floor on the left shoulder and left side of his/her head. The investigation directed the new intervention, staff to ask the resident if he/she would like to lay down in bed after lunch, to prevent the resident from trying to put him/herself to bed (repeated intervention from 2/16/15).

Nursing note dated 8/29/15 at 5:26 A.M., documented staff observed the resident stand up from the chair and attempt to sit back down, missed the chair and ended up sitting on the floor.

The facility provided incomplete investigation dated 8/29/15 at 5:20 A.M. documented recorded while in front of the nursing station, the resident stood up from the wheelchair and sat back down, missing the chair. The resident had unsteady gait, balance, and does not comprehend and cannot remember when educated. The investigation lacked a new intervention for staff.

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An incident note dated 8/30/15 at 1:16 A.M., documented the follow up from the residents falls on 8/28/15 and 8/29/15. Staff assessed the resident with a 10.3 centimeter by 7.3 centimeter dark purple bruise to left elbow.

Nursing note dated 9/7/15 at 5:28 P.M. revealed staff found the resident on the floor by the bathroom door, pants down to the thighs and a wet incontinence brief. The resident was unable to recall what he/she was doing.

The facility post fall investigation dated 9/14/15 for the incident 9/7/15 at 5:15 P.M. documented staff found the resident by the bathroom door, seated on the floor with his/her pants/briefs half-way down, unable to state what he/she was doing. The investigation documented an (unidentified) staff toileted the resident 30 minutes prior to the fall.

Observation on 9/18/15 at 12:25 P.M. revealed the resident in the south end of the assisted-living room transferred him/herself from the wheelchair to the sofa without staff knowledge.

On 9/18/15 at 12:27 P.M. licensed nursing staff G pushed the resident ' s wheelchair into his/her room close to the bed on the fall mat and encouraged the resident to stand and transfer to the bed. The resident stood bent over and scooted his/her feet to the edge of the bed and sat down. The resident was unable to lift his/her legs into the bed.
Observation revealed licensed nursing staff failed to use a gait belt for the transfer.

On 9/21/15 at 12:55 P.M., moved in the wheelchair into his/her room next to the bed.

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During this time, direct care staff L pushed an unsampled resident in a Broda chair past the resident ' s room. Direct care staff L looked in at the resident next to his/her bed in the wheelchair, then pushed the unsampled into the hall bathroom. Within a few seconds, the personal alarm sounds when the resident transferred him/herself to the bed. Direct care staff L runs out of the shower/bathroom and into the resident room and asked him/her if he/she was going to take a nap. Direct care staff attached the personal body alarm to the bed and adjusted the resident in the bed.

On 9/18/15 at 1:40 P.M. direct care staff N revealed the resident was a fall risk and elopement risk. The staff performed hourly safety checks, and the resident usually rested in bed in the afternoon. The resident required assistance with 2 staff and gait belt with transfers.

On 9/18/15 at 12:35 P.M. licensed nursing staff G reported the resident was a fall risk with a personal alarm and fall mat.

On 9/18/15 at 3:30 P.M. administrative nursing staff D reported, staff monitored the resident ' s location hourly, and the resident had safety alarms.

On 9/21/15 at 1:15 P.M. direct care staff O reported the resident always wandered and was a fall risk. The resident had a personal alarm and a fall mat just in case of a fall. Staff checked on the resident more frequently and he/she required 2 staff and a gait belt for transfers.

On 9/21/15 at 2:10 P.M., licensed nursing staff H reported staff monitored the resident hourly for

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safety checks. Licensed nursing staff reported, none of the residents were on more than hourly checks by staff.

The facility provided Gait Belt policy dated June 2009, purpose recorded the promotion of ambulation activity for residents on fall precautions, by providing increased security for the resident and staff and/or to provide security for transfers. Staff used gait belt to aid in the transferring and ambulating of all residents on fall precautions.

The facility provided undated Event Reporting Checklist directed to use the form as a guide and use good nursing judgment for the follow-through of all events. Staff immediately put interventions in place to prevent repeated falls, updated the care plan with the date, and new fall prevention intervention.

The facility provided policy Falls, Reporting, Investigation, and Prevention dated October 2010, provided a procedure with guidelines for assessing a resident after a fall, and to assist the staff in identifying the causes of the fall. The policy directed staff to review the resident ' s care plan to assess for any special needs of the resident. Within 24-hours of a fall, the nursing staff would begin to try to identify possible or likely causes of the incident.

Review of the facility provided incomplete investigations lacked evidence of any witnesses of the observed events or the root causative factors of each fall.

The facility failed to provide supervision, assistive devices, and effective interventions for this

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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cognitive impaired resident assessed as a high fall risk, to prevent falls.

- The clinical face sheet recorded the facility admitted resident #12 on 9/26/13 with diagnoses that included Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure, psychosis (any major mental disorder characterized by a gross impairment in reality testing), anxiety (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), and secondary parkinsonism (slowly progressive neurologic disorder characterized by resting tremor, rolling the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness).

The annual Minimum Data Set Assessment dated 1/21/15 documented the resident with a Brief Interview for Mental Status (BIMS) score of 00, which identified the resident with severe cognitive impairment. The resident wandered daily, experienced delusions, and required supervision of one staff for locomotion. The resident exhibited unsteady balance, only able to stabilize with staff assistance, and experienced two or more non-injury and one minor injury fall since the previous assessment.

Review of the Care Area Assessment (CAAs) dated 1/31/15 for cognition, documented the resident had poor short and long-term memory recall, poor safety awareness and a decreased ability to care for him/herself.

The CAA for falls dated 1/31/15 documented the resident wandered throughout the facility in a wheelchair. A physical therapy referral dated December 2015 recorded the resident was

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	17E294	A. BUILDING _____ B. WING _____	R-C 09/29/2015

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unable to follow commands to participate in therapy at that time.

The CAA for behaviors dated 1/31/15 documented the resident wandered daily throughout the facility in a wheelchair and had a personal body alarm on at all times. The facility doors had alarms on at all times.

The quarterly MDS dated 7/24/15 recorded the resident with a BIMS score of 1, which identified the resident with severe cognitive impairment. The resident wandered daily and required extensive assistance from two staff with all activities of daily living except eating. The resident exhibited unsteady balance and only able to stabilize with staff assistance, used a wheelchair for locomotion and experienced two or more non-injury falls since the previous assessment.

Review of the resident mobility assessment dated 7/18/15, documented the resident required assistance of 2 staff for transfers.

The Elopement Risk Assessment dated 7/18/15, documented a score of (11) which indicated a total of score of 11 or greater placed the resident at high risk to wander.

Review of the comprehensive care plan reviewed 8/27/15 identified the resident was an elopement risk and wanderer related to a diagnosis of Alzheimer's disease, which affected his/her memory and leads to him/her wandering aimlessly. The resident was disoriented to place and had a history of attempting to leave the facility unattended. The care plan directed staff to:

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*Redirect the resident when seeking to go through exit doors.
*Monitor the resident ' s location every 60 minutes. Document wandering behaviors in the wander log.
*Identify pattern of wandering. Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate.
An additional intervention added 6/13/15 documented staff replaced all pagers batteries with new ones and tested each one. Staff checked all doors for the sounding alarm.

A social service note dated 7/22/15 at 10:32 A.M. documented the resident wheeled his/her wheelchair all through the home on a daily basis and all throughout the day continuously going to the exit doors. The staff helped him/her and attempt to turn him/her around and stay inside the building.

Nursing note dated 7/28/15 at 1:07 P.M. recorded the resident wheeling him/herself in the wheelchair throughout day.

Nursing note dated 7/29/15 at 8:54 A.M. recorded the resident up and wandering.

Nursing note dated 8/6/15 at 3:39 A.M. recorded the resident had been up for approximately 2 hours, agitated, anxious, and exit seeking.

Nursing note dated 8/11/15 at 1:23 P.M. documented the resident had wandered a lot today, difficult to redirect.

Nursing note dated 8/12/15 at 1:07 P.M. documented the resident continued to exit seek,

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up and down the hallways with no real plan, except to get out the door.

Observation on 9/18/15 at 9:30 A.M. the resident moved about the facility self-propelling the wheelchair.
On 9/18/15 at 10:20 A.M. the resident set off the motion sensor alarm (two dings) into the assisted living and staff bring the resident back onto the long-term care unit.

On 9/18/15 at 12:10 P.M. constant observation revealed the resident, unattended by staff, entered the open assisted-living doorway and set off the motion sensor alarm (two dings) and pulled him/herself down the hall with the handrail. By 12:15 P.M. the resident was half-way down the hall into the assisted living. At 12:20 P.M. a visitor enters the facility and sets of the motion sensor into the assisted living, unnoticed by staff. The resident moved about in the assisted-living living room in his/her wheelchair, unattended by staff. At 12:25 P.M. the resident self-transfers to a couch in the south end of the assisted-living and sets of the resident ' s personal safety alarm. At 12:27 P.M. the surveyor and another visitor comes into the long-term care area from the assisting-living setting off the sensor alarm. Licensed nursing staff G and administrative staff D approach the nursing station and administrative staff D asked, " Now where is that coming from? " (Which referred to the persona alarm sounding). Licensed nursing staff G and administrative staff D hurried to the south end of the unattended assisted-living and observed the resident on the couch. Nursing staff transferred the resident back to the wheelchair and licensed nursing staff G pushed the resident in the wheelchair to his/her room. Licensed nursing staff

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pushed the wheelchair close to the bed on the fall mat, locked the wheelchair brakes, then encouraged the resident to stand up and sit on the bed. The resident with bent over posture, scooted his/her feet to the edge of the bed and sat. Licensed nursing staff instructed the resident to put his/her feet up on the bed, however, the resident was unable to lift his feet and place them on the low bed.

Observation revealed the resident was transferred by 1 staff, without the safety gait belt.

During an interview on 9/18/15 at 1:40 P.M. direct care staff N reported the resident was an elopement risk and staff performed hourly safety checks on the resident ' s location.

On 9/18/15 at 12:35 P.M. licensed nursing staff G reported the resident frequently wandered.

On 9/21/15 at 1:15 P.M. direct care staff O reported the resident always wandered and staff attempted to distract the resident.

On 9/18/15 at 3:30 P.M. administrative nursing staff D reported, staff did not restrict the resident from any part of the building, including the assisted living and staff monitored the resident ' s location hourly checks, and the resident had safety alarms.

On 9/21/15 at 2:10 P.M., licensed nursing staff H reported the resident goes and goes in his/her wheelchair. Licensed nursing staff H reported, none of the residents were on more than hourly checks by staff.

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{F 323}	Continued From page 58 The facility policy for elopement dated 7/24/15, directed staff removed the door to the Assisted-Living to lessen the sound barrier of the external door alarms. Staff placed a motion sensor temporarily to entry to the Assisted Living. This alarm would notify staff of any person entering or exiting the Assisting Living hallway. The facility failed to provide supervision and assistive devices to prevent the cognitively impaired resident from leaving the long-term care unit without staff knowledge.	{F 323}		